

“Thanatophobia”: Physician’s Perspective of Dealing with Patients with Fear of Death

Dear Editor,

We aim to explore the concept of “fear of death” (FOD) or “Thanatophobia” from a physician’s perspective. We discuss the nuances to Erik Erickson model, psychophysiology and evidence from literature on factors contributing to FOD, use psychoanalysis to explore a couple of hypothetical examples, provide a glimpse to technological nuance and current multidisciplinary approach.

PSYCHOPHYSIOLOGY

We focus on one model to explore this topic. This particular model described by Erik Erickson has been significantly modified to include a continuity model in the personality maturation process.^[1] Erik Erickson has described nine stages of psychosocial development. We focus on the 8th stage, i.e., “wisdom” looking at ego integrity versus despair.^[2] Interestingly this stage in its original form focuses on individual above 65 years of age, when they start to reflect on life’s achievements and disappointments. However, Erickson has stated that these stages are only phases, and after successful resolution at adolescence, there is a continuum of various conflicts and resolution.^[1] When an individual is terminally ill, this stage can occur out of sequence secondary to FOD and despair. This new situation brings along newer or younger or older conflicts adding to the physical ailment. We believe that the basic understanding of this model may prove beneficial to the treating physician in the context of managing the FOD in both adult and pediatric age group.

PSYCHOLOGICAL FACTORS ASSOCIATED WITH FEAR OF DEATH

There is evidence in the literature that certain factors contribute to FOD appearance.

In patients who do not have the following, FOD seems to be common:

- High self-esteem
- Religious beliefs
- Good health
- A sense of fulfillment in life
- Intimacy with family and friends
- A fighting spirit.

Certain other factors contributing to FOD include anxiety, depressive symptoms, and beliefs about what will happen after death. Death anxiety does not naturally follow the diagnosis of cancer. Unresolved psychological and physical distress underlies this psychological state.^[3] There are also evidence

from ounce psychological nursing that the first 100 days is the key in prevention of FOD.

COMPARISON TO POSTTRAUMATIC STRESS DISORDER AND MULTIPLE SCLEROSIS

FOD as a disease entity behaves very much like an initial anxiety due to a trauma leading to posttraumatic stress disorder (PTSD). We know that when anxiety in trauma is counseled properly early, PTSD can be thwarted in the root. Many such ends of life-care pathway has been included for multiple sclerosis patients early in their disease process.

CULTURAL BELIEFS, PREFERENCES AND RACE

In a study on metastatic cancer, researchers found differences in prediction of life expectancy between Black and White patients. Black patients predicted their expectancy based on religious beliefs while white patients predicted based on medical advice and science.^[4] However, this finding from the study can be debated and not necessarily be applicable to the wider population.

HYPOTHETICAL EXAMPLES

We take two hypothetical scenarios:

- 21-year-old man dying within 1 year of diagnosis of brain tumor
- A nonagenarian lady is dying of old age.

Aging is known to bring in some cognitive, physical, and psychological impairment. Improper resolution of the Erik Erickson’s concept of conflict will lead to FOD. Continuity principle occurs at all stages albeit the stages in the model are only a rough guide for the various age-related changes evolving in the psycho-social situation. For example, in the second scenario, if she develops urinary incontinence, she will have a minor conflict of autonomy versus shame that needs to be resolved in addition to the major conflict of integrity versus despair.

The corollary to the continuity principle is that one has to resolve all phases of conflict at all age groups, especially after adolescence. From a social perspective, an otherwise normal 21 years old will have his age appropriate conflict to resolve, but he has the added burden of having to deal with a short life span. If he did not mature fully (resolve all phases conflict irrespective of age) within a year, he will have an unresolved psychological state. It is this psychological state that underlies and brings in the FOD. If the team around him helps him look

back at his life and to develop integrity rather than despair, then he will develop wisdom and avoid the FOD.

PSYCHOANALYSIS

It may be of particular note that only a detailed psychoanalysis will reveal if there is significant FOD in the entire gamut of psychological symptoms. For example, an individual does not want to die because of his or her intimate family, but on further analysis, the same person may feel depressed of the fact that they are leaving this world. However, the intimacy will probably be enough to mask the debate of “integrity versus despair”.

TECHNOLOGY IN CARE

Virtual reality techniques decrease FOD experience. These techniques involve a virtual body and out of body experience (OBE).^[3] Earlier this year, Bourdin *et al.* demonstrated that the FOD in the experimental group was lower compared to the control group and also emphasizing the fact that naturally occurring OBEs are often associated with enhanced belief in life after death.^[5] Can this be incorporated in the care of patients who have an FOD? This is an ethical paradox and the question of when this can be introduced in a patient's care pathway is debatable. Nevertheless, this technological advancement may potentially change the perception of FOD.

COMMUNICATION AND COMPASSION IN CARE

Multidisciplinary approach in managing FOD is undoubtedly the best way in managing this condition. The team of allied health-care professionals and nurses can be appropriately trained to face this challenge. In the context of palliative care, a group of nurses who participated in a palliative care course along with nursing experience were better at dealing with the care of dying patients in a questionnaire-based study.^[6] Emergency care team that includes the paramedics, nurses, and doctors are more often in a situation of high anxiety regarding death and an interesting article focuses on recognizing the signs and symptoms of the death-related anxiety.^[7] Interventions that could prevent the debilitating effects of death anxiety, to improve staff's mental health and logically and practically to improve the care they provide to patients.^[7] Beyond empathy, a physician should support and understand their patients' needs in alleviating the FOD as belief systems differ between the individuals and the race.

CONCLUSION

We feel that the current evidence on the management of FOD lacks uniformity across the globe. Probably, the palliative care team faces this challenge more often than any other medical specialty but nevertheless as health professionals one should be aware of this sensitive and difficult topic. By exploring the various aspects contributing to this fear,

a treating professional can potentially be better equipped to face this challenge. Technology could prove beneficial in the paraphernalia of treatment options. We emphasize the need for a multidisciplinary team approach in managing FOD in a clinical context.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Access this article online	
Quick Response Code: 	Website: www.jnsbm.org
	DOI: 10.4103/jnsbm.JNSBM_102_17

How to cite this article: Balasubramanian C, Subramanian M, Balasubramanian S, Agrawal A, Raveendran S, Kaliaperumal C. “Thanatophobia”: Physician's perspective of dealing with patients with fear of death. *J Nat Sc Biol Med* 2018;9:103-4.

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